

		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0037291

Facility Name: RIVER VIEW MANOR, LTD

Address: 6131 PARK RIDGE ROAD LOVES PARK 61111
Number City Zip Code

County: WINNEBAGO

Telephone Number: (815) 633-6810 Fax # (815) 877-9353

IDPA ID Number: 36-3778807

Date of Initial License for Current Owners: 08/01/91

Type of Ownership:

<input type="checkbox"/>	VOLUNTARY, NON-PROFIT	<input checked="" type="checkbox"/>	PROPRIETARY	<input type="checkbox"/>	GOVERNMENTAL
<input type="checkbox"/>	Charitable Corp.	<input type="checkbox"/>	Individual	<input type="checkbox"/>	State
<input type="checkbox"/>	Trust	<input type="checkbox"/>	Partnership	<input type="checkbox"/>	County
IRS Exemption Code		<input checked="" type="checkbox"/>	Corporation	<input type="checkbox"/>	Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA Telephone Number: (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)		(Date)
	(Type or Print Name)	MELVIN SIEGEL	
	(Title)	PRESIDENT	
Paid Preparer	(Signed)	(SEE ATTACHED ACCOUNTANTS' REPORT)	
			(Date)
	(Print Name and Title)	BOB KAGDA PARTNER	
	(Firm Name & Address)	KRUPNICK BOKOR KAGDA & BROOKS, LTD 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124	
	(Telephone)	(847) 675-3585 Fax # (847) 675-5777	
MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630			

Facility Name & ID Number RIVER VIEW MANOR, LTD

0037291 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	54	Intermediate (ICF)	54	19,764	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	54	TOTALS	54	19,764	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF			401	401	8
9	SNF/PED					9
10	ICF	10,477	1,067		11,544	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,477	1,067	401	11,945	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 60.44%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care? YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets? YES ☐ NO ☒

I. On what date did you start providing long term care at this location? Date started 08/01/91

J. Was the facility purchased or leased after January 1, 1978? YES ☒ Date 08/01/91 NO ☐

K. Was the facility certified for Medicare during the reporting year? YES ☒ NO ☐ If YES, enter number of beds certified 11 and days of care provided 401

Medicare Intermediary ADMINISTAR

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number **RIVER VIEW MANOR, LTD** # **0037291** Report Period Beginning: **01/01/2004** Ending: **12/31/2004**

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	70,229	3,299	4,309	77,837		77,837		77,837			1
2	Food Purchase		48,744		48,744		48,744		48,744			2
3	Housekeeping	21,083	3,777		24,860		24,860		24,860			3
4	Laundry	8,903	4,713		13,616		13,616		13,616			4
5	Heat and Other Utilities			47,251	47,251		47,251	702	47,953			5
6	Maintenance	17,644		19,000	36,644		36,644	(2,544)	34,100			6
7	Other (specify):*			2,902	2,902		2,902	47	2,949			7
8	TOTAL General Services	117,859	60,533	73,462	251,854		251,854	(1,795)	250,059			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	445,829	11,189	3,960	460,978		460,978	3,826	464,804			10
10a	Therapy											10a
11	Activities	22,869	492	1,860	25,221		25,221	(1,860)	23,361			11
12	Social Services	15,840	700		16,540		16,540		16,540			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	484,538	12,381	5,820	502,739		502,739	1,966	504,705			16
	C. General Administration											
17	Administrative	49,999		3,000	52,999		52,999	647	53,646			17
18	Directors Fees											18
19	Professional Services			37,273	37,273		37,273	(13,879)	23,394			19
20	Dues, Fees, Subscriptions & Promotions			6,052	6,052		6,052	(1,458)	4,594			20
21	Clerical & General Office Expenses	40,804	2,478	16,861	60,143		60,143	18,580	78,723			21
22	Employee Benefits & Payroll Taxes			119,566	119,566		119,566		119,566			22
23	Inservice Training & Education			2,103	2,103		2,103	170	2,273			23
24	Travel and Seminar			4,908	4,908		4,908	2,988	7,896			24
25	Other Admin. Staff Transportation			15,995	15,995		15,995	2,278	18,273			25
26	Insurance-Prop.Liab.Malpractice			52,770	52,770		52,770	321	53,091			26
27	Other (specify):*			4,233	4,233		4,233	2,669	6,902			27
28	TOTAL General Administration	90,803	2,478	262,761	356,042		356,042	12,316	368,358			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	693,200	75,392	342,043	1,110,635		1,110,635	12,487	1,123,122			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE		SCHED REF	TOTAL
1	DIETARY		
	DIETITIAN CONSULTANT	XVIII B 35-2	4,309
	REPAIRS & MAINTENANCE		0
			0
			4,309
3	HOUSEKEEPING		
			0
			0
			0
4	LAUNDRY		
	EQUIPMENT REPAIRS & MAINTENANCE		0
			0
			0
5	HEAT & OTHER UTILITIES		
	GAS HEAT		20,064
	ELECTRICITY		17,199
	WATER		9,346
	CABLE TV - LOBBY		642
			0
			47,251
6	MAINTENANCE		
	GROUPS MAINTENANCE		260
	PAINTING & DECORATING		0
	BUILDING REPAIRS		0
	MAINTENANCE CONSULTANT		6,120
	EQUIPMENT MAINTENANCE & REPAIR		12,620
	ELEVATOR MAINTENANCE & REPAIR		0
	OUTSIDE LABOR		0
	EXTERMINATING SERVICE		0
	FIRE SERVICE		0
			0
			0
			0
			19,000
7	OTHER		
	SCAVENGER		2,354
	SECURITY SERVICE		548
			2,902
9	MEDICAL DIRECTOR		
	MEDICAL DIRECTOR FEES	XVIII B 36-2	0
			0

LINE		SCHED REF	TOTAL
10	NURSING		
	CONTRACT NURSING	XVIII C 53-2	0
	LABORATORY & XRAY EXPENSE		0
	PURCHASED SERVICES		0
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	3,660
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0
	PHARMACY CONSULTANT	XVIII B 39-2	0
	UTILIZATION REVIEW FEES	XVIII B __-2	0
	PHYSICIANS	XVIII B __-2	0
	PSYCHIATRIC	XVIII B __-2	0
	RN CONSULTANT	XVIII B 38-2	0
	GERIATRIC CONSULTANT		300
			0
			3,960
10a	THERAPY		
	PHYSICAL THERAPY SERVICES		0
	SPEECH THERAPY SERVICES		0
	OCCUPATIONAL THERAPY SERVICES		0
	REHABILITATION CONSULTANT	XVIII B __-2	0
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0
			0
11	ACTIVITIES		
	CABLE TV - PATIENT ROOMS		0
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	1,860
			0
			1,860
12	SOCIAL SERVICES		
	SOCIAL REHABILITATION SERVICES		0
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0
	SOCIAL WORKER	XVIII B 45-2	0
			0
			0
			0
13	NURSE AIDE TRAINING		
	NURSE AIDE TRAINING COSTS	XIII	0
			0

V.COST CENTER EXPENSES PAGE 3 COLUMN 3 OTHER

LINE	SCHED REF	TOTAL
14	PROGRAM TRANSPORTATION	
	PATIENT TRANSPORTATION	0
17	ADMINISTRATIVE	
	MANAGEMENT FEES XIX B	3,000
18	DIRECTORS FEES	0
19	PROFESSIONAL SERVICES	
	DATA PROCESSING XIX C	6,586
	ADMINISTRATIVE CONSULTANTS XIX C	0
	PROFESSIONAL FEES XIX C	15,395
	BOOKKEEPING/ADMINIST. SERVICE	15,292
20	FEES,SUBSCRIPTIONS,PROMOTIONS	37,273
	ENTERTAINMENT & MARKETING VI 19 XIX F	0
	ADV & PROMO-NON PATIENT RELATED VI 25 XIX F	518
	EMPLOYEE WANT ADS XIX F	702
	CONTRIBUTIONS VI 20 XIX F	180
	DUES & SUBSCRIPTIONS XIX F	2,359
	LICENSES & PERMITS XIX F	1,223
	PUBLIC RELATIONS-PATIENT RELATED XIX F	0
	ADVERTISING-YELLOW PAGES VI 28 XIX F	0
	TRUST FEES / FRANCHISE TAX / ETC VI 17 XIX F	0
	CONTRIBUTIONS - POLITICAL VI 20 XIX F	916
	HEALTH CARE WORKER BACKGROUND CHEC XIX F	154
21	CLERICAL & GENERAL OFFICE EXPENSES	6,052
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)	6,612
	EQUIPMENT REPAIR & MAINTENANCE	0
	OUTSIDE CLERICAL SERVICES	0
	PENALTIES / OVERDRAFT CHARGES VI 18	673
	HOME OFFICE EXPENSE	0
	THEFT & DAMAGE LOSS	0
	TELEPHONE	9,357
	MESSENGER SERVICE	219
		0
		16,861

LINE	SCHED REF	TOTAL
22	EMPLOYEE BENEFITS & PAYROLL TAXES	
	FICA TAXES XIX D	53,005
	UNEMPLOYMENT COMPENSATION XIX D	33,462
	WORKERS COMPENSATION INSURANCE XIX D	26,240
	HOSPITALIZATION INSURANCE XIX D	4,921
	EMPLOYEE BENEFITS - OTHER XIX D	1,938
	EMPLOYEE PHYSICAL EXAMS XIX D	0
	INSURANCE - EXECUTIVE LIFE VI 21/XIX D	0
	PENSION/PROFIT SHARING PLANS XIX D	0
	CHICAGO HEAD TAX XIX D	0
23	INSERVICE TRAINING & EDUCATION	119,566
	EDUCATION & SEMINARS	2,103
24	TRAVEL & SEMINARS	
	EDUCATION & SEMINARS XIX G	0
	TRAVEL XIX G	4,908
		0
		0
25	ADMIN. STAFF TRANSPORTATION	4,908
	TRANSPORTATION - STAFF	15,995
26	INSURANCE - PROP. LIAB & MALPRACTICE	
	GENERAL INSURANCE	52,770
27	OTHER	
	BAD DEBTS VI 24	4,233
		4,233

GRAND TOTAL COLUMN 3 OTHER 342,043

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			11,651	11,651		11,651	5,745	17,396			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			3,949	3,949		3,949	96,404	100,353			32
33	Real Estate Taxes			20,046	20,046		20,046		20,046			33
34	Rent-Facility & Grounds			111,599	111,599		111,599	(109,513)	2,086			34
35	Rent-Equipment & Vehicles			10,328	10,328		10,328	2,402	12,730			35
36	Other (specify):*											36
37	TOTAL Ownership			157,573	157,573		157,573	(4,962)	152,611			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,115	16,795	17,910		17,910		17,910			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			29,646	29,646		29,646		29,646			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		1,115	46,441	47,556		47,556		47,556			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	693,200	76,507	546,057	1,315,764		1,315,764	7,525	1,323,289			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,380)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(673)	21		18
19	Entertainment		20		19
20	Contributions	(1,096)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(4,233)	27		24
25	Fund Raising, Advertising and Promotional	(518)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (7,900)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	15,425		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 15,425		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 7,525		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	\$ 0	6	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
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28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

Summary A

12/31/2004

[illegible]

Summary B

12/31/2004

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		LITCHFIELD TERRACE	LITCHFIELD	MAVIN	SKOKIE, IL	COUNSULTING
		ARC OF JACKSONVILLE	JACKSONVILLE	ENTERPRISES, LTD.		BOOKKEEPING
SEE ATTACHED LIST		PARKVIEW TERRACE	EAST MOLINE			
		GOLDEN MOMENTS	JACKSONVILLE	MAVIN NURSING	SKOKIE, IL	REAL ESTATE
		SPRINGFIELD TERRACE	SPRINGFIELD	ASSOC LTD		
		VANDALIA TERRACE	VANDALIA			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

X YES

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	6	MAINTENANCE CONSULTANT	\$ 6,120	MAVIN ENTERPRISES, LTD		\$	\$ (6,120)	1
2	V	10	PSYCHO-SOCIAL CONSULTANT	1,860				(1,860)	2
3	V	11	ACTIVITIES CONSULTANT	1,860				(1,860)	3
4	V	19	ADMIN. /BKBP. FEES	14,418				(14,418)	4
5	V								5
6	V								6
7	V	5	ELECTRICITY/GAS				702	702	7
8	V	6	MAINTENANCE				3,576	3,576	8
9	V	7	SCAVENGER				47	47	9
10	V	10	PSYCH-SOCIAL & NURSING CONSULT				5,686	5,686	10
11	V	17	ADMINISTRATIVE SALARIES				647	647	11
12	V	19	PROFESSIONAL FEES				539	539	12
13	V	20	ADVERTISING				156	156	13
14	Total			\$ 24,258			\$ 11,353	\$ * (12,905)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	21	TOTAL OFFICE	\$	MAVIN ENTERPRISES, LTD.		\$ 19,253	\$ 19,253	15
16	V	23	SEMINARS				170	170	16
17	V	24	TRAVEL				2,988	2,988	17
18	V	25	TRANSPORTATION				2,278	2,278	18
19	V	27	EMPLOYEE BENEFITS				6,902	6,902	19
20	V	30	DEPRECIATION (SL)				163	163	20
21	V	32	INTEREST				76	76	21
22	V	34	OFFICE RENT				2,086	2,086	22
23	V	35	EQUIPMENT RENT				2,402	2,402	23
24	V	26	INSURANCE				321	321	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$ 36,639	\$ * 36,639	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒ YES☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	\$ 111,599	MAVIN NURSING ASSOC. LTD. PARTNERSHIP		\$	\$ (111,599)	15
16	V	30	DEPRECIATION				6,962	6,962	16
17	V	32	INTEREST				96,328	96,328	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 111,599			\$ 103,290	\$ * (8,309)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5	SEE ATTACHED SCHEDULE										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number RIVER VIEW MANOR, LTD # 0037291 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization MAVIN ENTERPRISES, LTD.
Street Address 3845 OAKTON
City / State / Zip Code SKOKIE, IL 60076
Phone Number (847) 679-0100
Fax Number (847) 679-0647

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	5	ELECTRICITY/GAS	PATIENT DAYS	143,912	7	\$ 9,847	\$	10,257	\$ 702	1
2	6	MAINTENANCE	PATIENT DAYS	143,912	7	50,182	50,150	10,257	3,576	2
3	7	SCAVENGER	PATIENT DAYS	143,912	7	661		10,257	47	3
4	10	PSYCH-SOCIAL & NURSING C	PATIENT DAYS	143,912	7	79,777		10,257	5,686	4
5	17	ADMINISTRATIVE SALARIES	PATIENT DAYS	143,912	7	9,075	9,075	10,257	647	5
6	19	PROFESSIONAL FEES	PATIENT DAYS	143,912	7	7,562		10,257	539	6
7	20	ADVERTISING	PATIENT DAYS	143,912	7	2,189		10,257	156	7
8	21	TOTAL OFFICE	PATIENT DAYS	143,912	7	270,128	213,321	10,257	19,253	8
9	23	SEMINARS	PATIENT DAYS	143,912	7	2,385		10,257	170	9
10	24	TRAVEL	PATIENT DAYS	143,912	7	41,923		10,257	2,988	10
11	25	TRANSPORTATION	PATIENT DAYS	143,912	7	31,958		10,257	2,278	11
12	27	EMPLOYEE BENEFITS	PATIENT DAYS	143,912	7	96,841		10,257	6,902	12
13	30	DEPRECIATION (SL)	PATIENT DAYS	143,912	7	2,285		10,257	163	13
14	32	INTEREST	PATIENT DAYS	143,912	7	1,072		10,257	76	14
15	34	OFFICE RENT	PATIENT DAYS	143,912	7	29,270		10,257	2,086	15
16	35	EQUIPMENT RENT	PATIENT DAYS	143,912	7	33,698		10,257	2,402	16
17	26	INSURANCE	PATIENT DAYS	143,912	7	4,499		10,257	321	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 673,352	\$ 272,546		\$ 47,992	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	RELATED PARTY						\$				\$	1
2	MAVIN NURSING ASSOC.											2
3	FIFTH/THIRD BANK		X	MORTGAGE	\$12,416.00	12/99	1,250,000	1,163,799	12/14/04	8.5000	96,328	3
4												4
5	MGMT ALLOCATION										76	5
	Working Capital											
6	A.I. CREDIT CORPORATION		X	INSURANCE FINANCE							3,949	6
7												7
8												8
9	TOTAL Facility Related				\$12,416.00		\$ 1,250,000	\$ 1,163,799			\$ 100,353	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						\$	\$			\$	14
15	TOTALS (line 9+line14)						\$ 1,250,000	\$ 1,163,799			\$ 100,353	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ N/A Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.			
1. Real Estate Tax accrual used on 2003 report.			\$	19,955	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	19,901	2
3. Under or (over) accrual (line 2 minus line 1).			\$	(54)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	20,100	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	20,046	7
Real Estate Tax History:					
Real Estate Tax Bill for Calendar Year:		1999	17,768	8	
		2000	18,954	9	
		2001	19,147	10	
		2002	19,757	11	
		2003	19,901	12	
THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL				13	FROM R. E. TAX STATEMENT FOR 2003 \$ 13
				14	PLUS APPEAL COST FROM LINE 5 \$ 14
				15	LESS REFUND FROM LINE 6 \$ 15
THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

RIVER VIEW MANOR, LTD

COUNTY

WINNEBAGO

FACILITY IDPH LICENSE NUMBER

0037291

CONTACT PERSON REGARDING THIS REPORT

BOB KAGDA

TELEPHONE (847) 675-3585

FAX #: (847) 675-5777

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	11-01-252-012	NURSING HOME	\$ 19,004.92	\$ 19,004.92
2.	11-01-177-016	NURSING HOME	\$ 895.94	\$ 895.94
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 19,900.86	\$ 19,900.86

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

2

C. Does the Operating Entity?

☐

(a) Own the Facility

☒

(b) Rent from a Related Organization.

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization.

☒

(c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1				\$	1
2	MAVIN NURSING			45,219	2
3	TOTALS			\$ 45,219	3

Facility Name & ID Number RIVER VIEW MANOR, LTD

0037291

Report Period Beginning:

01/01/2004

Ending:

12/31/2004

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	54		1991		\$ 219,321	\$ 6,962	31.5	\$ 6,962	\$	\$ 92,874	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS		1992		5,735	199	20	287	88	2,814	9
10	VARIOUS		1993		13,400	344	20	667	323	6,611	10
11	VARIOUS		1994		1,854	48	20	93	45	970	11
12	VARIOUS		1995		4,453	114	20	223	109	2,082	12
13	FLOORING/CARPET		1996		1,791	46	20	90	44	810	13
14	HOT WATER HEATER		1996		1,009	26	20	50	24	450	14
15	VINYL TILE		1996		875	22	20	44	22	381	15
16	VINYL TILE		1996		1,309	34	20	65	31	558	16
17	COMPRESSOR		1996		1,422	36	20	71	35	592	17
18	ROOF REPAIRS		1996		2,000	51	20	100	49	808	18
19	WALL COVERING		1996		608	16	20	30	14	257	19
20	ROOF-SITTING ROOM		1997		9,193	196	20	460	264	3,603	20
21	FLOOR TILE		1997		2,256	58	20	113	55	857	21
22	NURSING CALL SYSTEM REPAIRS		1997		1,834	47	20	92	45	667	22
23	NURSING CALL SYSTEM REPAIRS		1997		3,265	84	20	163	79	1,195	23
24	NURSING CALL SYSTEM REPAIRS		1997		1,845	47	20	92	45	667	24
25	NURSING CALL SYSTEM REPAIRS		1997		1,140	29	20	57	28	413	25
26	NURSING CALL SYSTEM REPAIRS		1997		1,410	36	20	71	35	515	26
27	NURSING CALL SYSTEM REPAIRS		1997		1,230	32	20	62	30	450	27
28	NURSING CALL SYSTEM REPAIRS		1997		2,082	53	20	104	51	752	28
29	ROOF		1999		5,000	128	20	250	122	1,500	29
30	INSTALLED OF NEW DURO-LAST ROOF		2000		70,200	2,553	27.5	2,553		12,339	30
31	BACK FLOW PREVENTER FOR MAIN WATER LINE		2000		2,750	100	27.5	100		450	31
32	INSTALLED NEW HEAT EXCHANGE & CYCLED UNIT		2000		1,871	68	27.5	68		306	32
33	COMMERCIAL SECURITY SYSTEM		2000		6,315	230	27.5	230		1,035	33
34	INSTALLATION OF THE CCTV SYSTEM		2001		3,881	141	27.5	141		493	34
35	FLOORING-BATHROOMS, RESIDENT ROOMS		2001		4,448	162	27.5	162		567	35
36	NEW SIDEWALK		2002		11,846	431	27.5	431		664	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$384,343	\$12,293		\$13,831	\$1,538	\$135,680	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)								
	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$37,319	\$3,861	\$3,197	\$(664)	5-10YRS	\$20,306	71
72	Current Year Purchases	4,098	2,459	205	(2,254)	10YRS	205	72
73	Fully Depreciated Assets							73
74	MGMT ALLOCATION		163	163				74
75	TOTALS	\$41,417	\$6,483	\$3,565	\$(2,918)		\$20,511	75

D. Vehicle Depreciation (See instructions.)*									
	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9
76	FACILITY	VEHICLE REHAB	1994	\$6,539	\$	\$	\$		\$6,539
77									
78									
79									
80	TOTALS			\$6,539	\$	\$	\$		\$6,539

E. Summary of Care-Related Assets					1	2
		Reference				Amount
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)			\$	477,518
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)			\$	18,776
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)			\$	17,396
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)			\$	(1,380)
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)			\$	162,730

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)				
	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4
86		\$	\$	\$
87				
88				
89				
90				
91	TOTALS	\$	\$	\$

G. Construction-in-Progress		
	Description	Cost
92		\$
93		
94		
95		\$

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A - RELATED PARTY
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☐ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease
-

9. Option to Buy:
- ☐ YES☐ NO
- Terms:
- *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
- ☐ YES☒ NO
16. Rental Amount for movable equipment: \$8,090
- Description: SEE SCHEDULE ATTACHED
- (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	ADMINISTRATOR	2001 NISSAN	\$198.00	\$2,238	17
18					18
19					19
20					20
21	TOTAL		\$198.00	\$2,238	21

10. Effective dates of current rental agreement:

Beginning

Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	\$
13.	/2006	\$
14.	/2007	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

B. EXPENSES		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED	
COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 8,156	\$		\$ 8,156	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			247			247	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			8,392			8,392	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				1,115		1,115	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			\$		\$ 16,795	\$ 1,115	\$	17,910	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ (31,399)	\$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	363,939		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	27,074		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	738,830		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,098,444	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	165,021		15
16	Equipment, at Historical Cost	47,957		16
17	Accumulated Depreciation (book methods)	(70,701)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	6,503		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 148,780	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 1,247,224	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 309,646	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	1,414,986		29
30	Accrued Salaries Payable	26,098		30
31	Accrued Taxes Payable (excluding real estate taxes)	84,024		31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,100		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 1,854,854	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,854,854	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (607,630)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 1,247,224	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (436,410)	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	19,367	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (417,043)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(190,587)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (190,587)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (607,630)	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 1,114,657	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,114,657	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	10,520	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 10,520	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,125,177	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	251,854	31
32	Health Care	502,739	32
33	General Administration	356,042	33
	B. Capital Expense		
34	Ownership	157,573	34
	C. Ancillary Expense		
35	Special Cost Centers	17,910	35
36	Provider Participation Fee	29,646	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,315,764	40
41	Income before Income Taxes (line 30 minus line 40)**	(190,587)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (190,587)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.
TAX RETURN PREPARED ON CASH BASIS

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,120	2,248	\$ 55,460	\$ 24.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,786	1,852	42,967	23.20	3
4	Licensed Practical Nurses	6,684	7,066	128,973	18.25	4
5	Nurse Aides & Orderlies	19,151	20,187	189,780	9.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	2,021	2,141	22,869	10.68	10
11	Social Service Workers	1,010	1,042	15,840	15.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	7,652	8,177	70,229	8.59	15
16	Dishwashers					16
17	Maintenance Workers	1,295	1,613	17,644	10.94	17
18	Housekeepers	2,751	2,841	21,083	7.42	18
19	Laundry	1,469	1,473	8,903	6.04	19
20	Administrator	1,928	2,080	49,999	24.04	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,057	2,161	40,804	18.88	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Care Plan Coord	1,206	1,255	28,649	22.83	33
34	TOTAL (lines 1 - 33)	51,130	54,136	\$ 693,200 *	\$ 12.80	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	M	\$ 4,309	1-3	35
36	Medical Director	O	0	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	1,860	11-3	44
45	Social Service Consultant	E	0	12-3	45
46	Other(specify)	S			46
47	PSYCHO-SOCIAL		3,660	10-3	47
48	GERIATRIC CONSULTANT		300	10-3	48
49	TOTAL (lines 35 - 48)		\$ 10,129		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		\$		53

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	Ownership %	Amount	Description		Amount	Description		Amount		
PEGGY RAHKONEN	ADMIN	0	\$ 49,999	Workers' Compensation Insurance		\$ 26,240	IDPH License Fee		\$ 750		
				Unemployment Compensation Insurance		33,462	Advertising: Employee Recruitment		702		
				FICA Taxes		53,005	Health Care Worker Background Check		154		
				Employee Health Insurance		4,921	(Indicate # of checks performed 11)				
				Employee Meals		#REF!	MARKETING/ADV/PROMO		518		
				Illinois Municipal Retirement Fund (IMRF)*			TRUST/FRANCHISE/CONTRIB/ETC		1,096		
				EMPLOYEE BENEFITS - OTHER		1,938	LICENSES & PERMITS		473		
				EMPLOYEE PHYSICAL EXAMS		0	DUES & SUBSCRIPTIONS		2,359		
				PENSION/PROFIT SHARING PLANS		0	MGMT CO ALLOCATION		156		
				CHICAGO HEAD TAX		0	TRUST/FRANCHISE/CONTRIB/ETC		(1,096)		
				INSURANCE - EXECUTIVE LIFE		0	Less: Public Relations Expense		(0)		
				INSURANCE - EXECUTIVE LIFE VI 21		0	Non-allowable advertising		(518)		
							Yellow page advertising		(0)		
TOTAL (agree to Schedule V, line 17, col. 1)				TOTAL (agree to Schedule V, line 22, col.8)		\$ #REF!	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 4,594		
(List each licensed administrator separately.)			\$ 49,999								
B. Administrative - Other											
Description			Amount								
MELVIN SIEGEL	MANAGEMENT FEES		\$ 3,000								
TOTAL (agree to Schedule V, line 17, col. 3)			\$ 3,000								
(Attach a copy of any management service agreement)											
C. Professional Services											
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description		Amount	
KRUPNICK, BOKOR, KAGDA	ACCOUNTING FEES		\$ 9,800					Out-of-State Travel		\$	
GARY A. WEINTRAUB	LEGAL FEES		3,275								
ALPHA DATA SERVICES	DATA PROCESSING		1,767								
NURSING CARE SYSTEMS	DATA PROCESSING		2,951					In-State Travel			
LTC SOLUTIONS	DATA PROCESSING		1,320							4,908	
BEST SOFTWARE OF CALIF.	DATA PROCESSING		457					MGMT ALLOCATION		2,988	
IVANS	DATA PROCESSING		91								
PERSONNEL PLANNERS	U. C. CONSULTANT		1,564					Seminar Expense			
MAVIN ENTERPRISES	BOOKKEEPING/ADMIN.		14,418							0	
SAK MANAGEMENT	BOOKKEEPING/ADMIN.		874								
SHARON HAUGH	MEDICARE CONSULTANT		756								
TOTAL (agree to Schedule V, line 19, column 3)				TOTAL			\$	Entertainment Expense		()	
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 37,273					(agree to Sch. V, line 24, col. 8)		\$ 7,896	

* Attach copy of IMRF notifications

**See instructions.

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL OF LONG TERM CARE \$2,359
- (3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10 YR
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ _____ Line 10-2
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 29,646
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefit: on Schedule V. \$ #REF! Has any meal income been offset against related costs? _____ Indicate the amount. \$ _____
- (16) Travel and Transportation
- a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
- b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
- c. What percent of all travel expense relates to transportation of nurses and patients? 5%
- d. Have vehicle usage logs been maintained? NO
- e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
- f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? YES
- g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm? NO
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees